pure elevate your health

#207, 4807 - 50 Avenue, Red Deer, AB
403-348-8222 | hello@purereddeer.com
purereddeer.com

Welcome to Pure. Please complete the following forms. Information collected is used to determine care required based on your current condition. After you are finished filling out these forms, you will meet with one of our highly trained staff members, who will review your history with you. Based on your history, certain examinations will be performed, including spinal images if necessary. Your case will then be reviewed by our team of practitioners and one of them will review your exam findings with you.

Please be prepared to spend about 60 minutes with us today.

CONFIDENTIAL PATIENT HISTORY

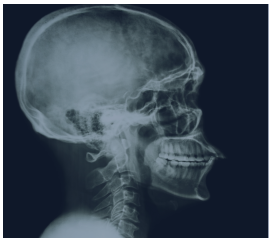
Name _____ Date: _____
Address _____ City _____ Postal Code _____
Home Phone _____ Business Phone _____ Cellular/Other _____
Date of Birth _____ Email* _____ Sex ___M ___F Age _____
Number of Sibling's _____ Name and Ages of Siblings _____
Have you ever been to: ___Chiropractor ___Massage Therapist ___Physiotherapist ___Nutritionist
If yes to any of the above, what clinic? _____
How did you hear about Pure? _____
Name of Family Medical Doctor _____ Alberta Health Care Number _____
*Your email will be used for email appointment reminders and office communication pertaining to your care.

PATIENT HEALTH STRESSORS

There are many lifestyle stressors that can effect your health. Please answer the following questions regarding lifestyle stressors.

STRESS LEVELS

Are there smokers in your home? Y N
Is there stress in your infant's life? Y N
How many hours of sleep does your infant get nightly? _____
What do you perceive to be your infant's greatest stressor? _____
PRACTITIONER NOTES:
_____
_____



NERVE SUPPLY

Is your infant lethargic? Y N
Does your infant have too much energy? Y N
Does your infant have trouble staying focused? Y N
Any previous history of concussions? Y N
Did the birth require any interventions? Y N
PRACTITIONER NOTES:
_____
_____

FUEL AND OXYGEN

Does your infant have digestive issues? Y N
Do you have any breathing problems? Y N
At what age were solid foods introduced? _____
What did your child eat for breakfast today? _____
What is your child's favourite vegetable? _____
PRACTITIONER NOTES:
_____
_____

MOVEMENT

Does your infant have any difficulty with certain movements? Y N
Did your infant favour one side when breast feeding? Y N
At what age did your infant walk?_____ sit?_____ crawl?_____
How much tummy time does your infant get a day? _____
PRACTITIONER NOTES:
_____
_____

ABOUT YOUR HEALTH

Please check the appropriate boxes for symptoms that you have experienced:

MUSCLE AND JOINT
- O Backache
- O Neck pain
- O Painful tailbone
- O Foot trouble
- O Shoulder pain
- O Herniated disc
- O Spinal curvature
- O Faulty posture
- O Arthritis

STRESS SYMPTOMS
- O Headaches/Migraines
- O Dizziness
- O Numbness
- O Ringing in ears
- O Blurring of vision
- O Loss of sleep
- O Loss of concentration
- O Irritable/Nervousness
- O Depression
- O Decreased Energy/fatigue
- O Tension

RESPIRATORY
- O Spitting up phlegm/blood
- O Chest pain
- O Difficulty breathing

URINARY
- O Painful urination
- O Urinating at night
- O Blood in urine
- O Increased urination

GASTROINTESTINAL
- O Difficult digestion
- O Belching or gas
- O Nausea or vomiting
- O Pain over stomach
- O Constipation
- O Colon trouble
- O Liver trouble
- O Gall bladder trouble
- O Heartburn
- O Diarrhea
- O Bloody stools

CARDIOVASULAR
- O Rapid heart beat
- O Slow heart beat
- O High blood pressure
- O Low blood pressure
- O Pain over heart
- O Swelling of ankles
- O Previous heart attack
- O Poor circulation
- O Previous stroke
- O Heart Disease

GENERAL
- O Fever/chills/sweat
- O Fainting
- O Convulsions
- O Skin problems
- O Colds
- O Tremors
- O Loss of balance
- O Allergies:

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EYES, EARS, NOSE, THROAT
- O Deafness
- O Earache
- O Sore throat
- O Asthma
- O Tonsillitis
- O Sinus trouble

FEMALES ONLY
- O Painful menstruation
- O Excessive flow
- O Irregular cycle
- O Cramps or backache
- O Abnormal discharge
- O Past menopause
- O Birth control pill

PAST HEALTH
- O Thyroid troubles
- O Diabetes
- O Tuberculous
- O Emotional problems
- O Epileptic seizures
- O Asthma
- O Artritis
- O Alcoholism
- O Polio
- O Cancer
- O Venereal disease
- O HIV

MEDICATIONS:

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ACCIDENTS/SURGERIES

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FAMILY HEALTH HISTORY
- O Heart disease
- O Diabetes
- O Cancer
- O Fatigue
- O Asthma
- O High blood pressure
- O Low blood pressure
- O Thyroid
- O Arthritis
- O Low back pain
- O Anxiety
- O Scoliosis

PATIENT HEALTH HISTORY

What is your child's major symptom? ____

When was the first time you noticed this problem? ____________________________________

How did it originally occur? ____

Has it become worse recently? ___Yes ___No ___Same ___Better ___ Gradually

If yes, when and how? ____

How frequent is the condition? ___Constant ___Daily ___Intermittent ___Nightly

How long does it last? ___All day ___Few hours ___Minutes

Do they have any other conditions or symptoms that may be related to your major symptom? ___Yes ___No

If yes, ____

Are there other unrelated health problems? ___Yes ___No

If yes, ____

Describe the pain: ___Sharp ___Dull ___Numbness ___Tingling ___ Aching ___Burning ___ Stabbing

Other: ____

Is there anything you can do to relieve the problem? ___Yes ___No If yes, how? ________

If no, what have you tried that has not helped? ______________________________

What makes the problem worse? ___Standing ___Sitting ___Laying ___Bending ___ Lifting ___Twisting

Other: ____

Have you had any broken bones? ___Yes ___No

If yes, list with dates: ____

Have you had any diseases, major illnesses or injuries not indicated on this form either in the past or the present?

___Yes ___No If yes, ____

PRACTITIONER NOTES:

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SYMPTOM SCALE *(please draw a line on the following scale)*

NO SYMPTOMS ____ EXTREME SYMPTOMS

CONSENT TO CARE

I, ____________________________ consent to receiving rehabilitation services, and/or a consultation, an examination and x-rays, (if necessary) to determine if I am a candidate for care at PURE.

Services may include: heat therapy, muscular stimulation, acupuncture, joint/spinal mobilization/manipulation, myofascial release, interferential, gait analysis, and exercise prescription.

I understand that health practitioners within PURE may share my health information between them in order to give me the highest level of care. I understand that all information shared between practitioners will remain completely confidential within PURE.

Child's Name:____ Date:______________________________

Parent/Legal Guardian's Signature : ______________________________ Witnessed: ______________________________